FORM 133A

The Commonwealth of Massachusetts
Department of Industrial Accidents
600 Washington Street – 7th Floor, Boston Massachusetts 02111
Info. Line (800) 323-3249 ext. 470 in Mass. Outside Mass. - (617) 727-4900 ext. 470
http://www.mass.gov/dia

DIA Board #
(If Known):

UTILIZATION REVIEW AGENT COMPLAINT FORM

The Code of Massachusetts Regulations, 452 CMR 6.07, requires that the Department of Industrial Accidents monitor the utilization review techniques used, and the determinations made, by utilization review agents. The Department receives and investigates complaints from providers, employers and employees regarding the conduct of utilization review agents believed to be in violation of **452 CMR 6.0 *et seq*.**, the workers' compensation Utilization Review and Quality Assessment regulation. Please check the appropriate box below to indicate the category to which this complaint relates.

The UR Agent has ***not***:

- ☐ rendered a notice of any kind to either the Employee or the Provider
- ☐ rendered a notice of **Adverse Determination** to both Employee and Provider [6.04(4)(b)]
- ☐ rendered a notice of adverse determination to both Employee and Provider within the **time constraints** [6.04(4)(b)]
- ☐ made its **Appeal-Level Determination** within the time constraints [6.04(4)(c)]
- ☐ provided a review by a **Same-School Practitioner** when rendering an appeal-level determination [6.04(4)(c)1]
- ☐ provided the **Review Criteria** used to make an adverse determination [6.04(4)(c)]
- ☐ provided all the **Reasons** used to reach an adverse determination [6.04(4)(c)]
- ☐ provided the Employee with a notice of **Rights and Responsibilities** [6.04(2)(d)]
- ☐ complied with **telephone requirements** for UR Agent availability and staffing [6.04(4)(d)]
- ☐ issued an **identification card**, if delegated to the UR Agent by the insurer [6.04(4)(e)]
- ☐ complied with 452 CMR 6.0 *et seq.* in some **other** way (specify):_____

TO FILE A COMPLAINT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

TODAY'S DATE: _____

NAME OF PERSON FILING COMPLAINT:_____

ADDRESS: _____

CITY/STATE/ZIP: _____

TEL: (____)_____

YOU ARE: (**Please Check One**):

☐ PROVIDER ☐ EMPLOYER ☐ EMPLOYEE ☐ OTHER

PLEASE NOTE: You are required to inform the injured employee of this filing. The injured employee will be cross-copied all responses and exhibits received during the course of the complaint investigation.

INJURED EMPLOYEE'S NAME:_____

ADDRESS:_____

CITY/STATE/ZIP:_____ **TEL: (____)**_____

EMPLOYER:_____ INSURER:_____

ADDRESS:_____ ADDRESS:_____

CITY/STATE/ZIP:_____ CITY/STATE/ZIP:_____

TEL: (____)_____ TEL: (____)_____

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT THE *UTILIZATION REVIEW AGENT*:

UR AGENT'S NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: (_____)_____ DATE(S) OF CONTACT: _____

_____

_____

Using the following space, **summarize your complaint** about the UR Agent. In addition, attach copies of any other documentation to this form that supports your complaint including correspondence from the UR Agent, specific dates of contact with the UR Agent, person(s) contacted, etc.:

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SEND THIS COMPLETED FORM AND ANY ATTACHMENTS TO:

Department of Industrial Accidents
Office of Health Policy
600 Washington Street, 7th Floor
Boston, MA 02111

A COPY OF THIS COMPLAINT AND ALL ATTACHMENTS WILL BE FORWARDED TO THE UR AGENT.